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FISCAL IMPACT STATEMENT

LS 7351
BILL NUMBER: SB 464

NOTE PREPARED: Feb 6, 2015
BILL AMENDED: Feb 5, 2015

SUBJECT: Mental Health Drugs.

FIRST AUTHOR: Sen. Miller Patricia
FIRST SPONSOR:

BILL STATUS: CR Adopted - 1st House

FUNDS AFFECTED: X **GENERAL**
DEDICATED
X **FEDERAL**

IMPACT: State & Local

Summary of Legislation: (Amended) This bill has the following provisions:

A. *Use of Long-Acting, Nonaddictive Medication in Community Supervision* – It provides that addictions counseling, inpatient detoxification, and long-acting, nonaddictive medication may be required to treat opioid or alcohol addiction as a condition of parole, probation, community corrections, pretrial diversion, or participation in a problem-solving court.

B. *Methadone Provision* - The bill prohibits coverage by: (1) the state employee health plan; (2) Medicaid; (3) certain policies of accident and sickness; and (4) certain health maintenance organization contracts; of methodone if the drug is prescribed for the treatment of pain. It requires a prescriber who is prescribing methadone for the treatment of pain or pain management to indicate this treatment on the prescription or order.

C. *Expansion of Medicaid Benefits* – It includes inpatient substance abuse detoxification services as a Medicaid service. It prohibits the Office of Medicaid Policy and Planning (OMPP) from requiring prior authorization for a drug that is a nonaddictive medication assistance treatment drug being prescribed for the treatment of substance abuse. It requires coverage under the Indiana Check-up Plan of nonaddictive medication assistance treatment drugs prescribed for the treatment of substance abuse.

D. *Drug Utilization Review Board (DUR Board)* - The bill requires the DUR Board to review the prescribing and reimbursement for long-acting addictive medication-assistance treatment drugs for the treatment of pain and for the treatment of substance abuse. It requires the DUR Board to report

its findings to the General Assembly not later than December 1, 2015.

E. *Opioid Treatment Programs*– The bill authorizes the Division of Mental Health and Addiction (DMHA) to approve before June 30, 2018, not more than five new opioid treatment programs if the programs are run by a hospital or a certified community mental health center (CMHC). It also requires the DMHA to report to the General Assembly before July 1, 2018, specified information concerning any new facilities.

F. *Repeal of Department of Correction (DOC) Requirement* – It repeals the requirement that the DOC estimate, prior to March 1, 2015, the amount of any operational savings that will be realized in FY 2015 from a reduction in the number of individuals who are in the custody or made a ward of DOC.

Effective Date: July 1, 2015.

Summary of NET State Impact: (Revised) The inclusion of inpatient substance abuse detoxification services as a Medicaid State Plan service may require the state to increase the access to the service due to the limited number of providers available. Since demand is reported to be higher than the supply, total cost of the service could go up if the supply is expanded.

Expansion of the number of opioid treatment programs through the community mental health centers would have a fiscally neutral effect on the Division of Mental Health and Addiction (DMHA). The DMHA reported that expanded treatment options could reduce emergency department use and inpatient admissions for substance abuse.

The Healthy Indiana Plan (HIP) 2.0 waiver includes inpatient and outpatient substance abuse treatment in the alternative benefit plans, although the scope of the services is not known at this time. Chronic substance abusers may enroll in the HIP 2.0 Medically Frail group that receives full Medicaid State Plan services. The Medicaid expansion will add coverage for a population known to have increased risk for substance abuse disorders.

The prohibition on Medicaid, managed care organizations, the state employee health plans, and accident and sickness insurance policies from paying for methadone when prescribed for pain has an indeterminate impact.

Explanation of State Expenditures: (Revised) *Use of Medication-Assisted Treatment in Community Supervision*: The bill language is permissive and would allow chemical addiction treatment to be required for addicted offenders who are on parole, probation, in community corrections, on pretrial diversion, or participating in a problem-solving court. The bill specifies that medication-assisted treatment may include long-acting nonaddictive medication. The costs of requiring participation will depend on the orders of the DOC or a court, the number of addicted offenders that might qualify for Medicaid, and if all the treatment costs would be included as allowable benefits within the HIP 2.0 waiver approved for the statewide Medicaid expansion.

(Revised) *New Opioid Treatment Programs (OTP):* The bill would allow up to 5 certified community mental health centers (CMHC) or general acute care hospitals to apply to the DMHA to operate a new opioid treatment program through June 30, 2018. The DMHA would have administrative and regulatory oversight responsibility for up to 5 additional treatment programs. DMHA reported that an expansion would require

additional resources. However, additional administrative costs in this program are cost-neutral to DMHA since administrative costs associated with the OTPs are billed back to the programs on a per person basis. The ultimate fiscal impact of this provision would depend on the number of CMHCs or hospitals that would choose to apply to operate an OTP and how fees are structured to recover the DMHA administrative costs - these costs could be transferred to other funding streams.

(Revised) *Reporting Requirements:* The DMHA is required to report by June 30, 2018, specified information to the General Assembly regarding any new OTPs that may have been added. The DMHA currently has several annual reporting requirements with regard to OTPs. This additional report may be accomplished within the level of administrative resources available.

The DUR Board is required to study prescribing and reimbursement for addictive drug therapies used to treat substance abuse. The results are to be reported to the Legislative Council by December 1, 2015. It is not known at this time if the study can be accomplished within the level of resources available to the DUR Board. [*This information will be updated when available*.]

Repeal of Department of Correction (DOC) Requirement – Currently, DOC is required to estimate any savings that it can identify from the passage of HEA 1006 in 2013 and HEA 1006 in 2014 by March 1, 2015. Any savings that it identifies from these bills can be used for community corrections programs or for probation programs. This language would be repealed. Consequently, any operational savings could be used for other programs or reverted to the state General Fund.

Expansion of Medicaid Benefits-

(Revised) *Administrative costs:* The Family and Social Services Administration (FSSA) may be required to submit Medicaid State Plan amendments (SPA) to add inpatient substance use detoxification services as a State Plan service. The bill may also require that the HIP 2.0 waiver be amended in order to include nonaddictive substance abuse treatment drugs in the plan benefits. If amendments are required, SPAs and waiver amendments are a core function of the Medicaid program and should be accomplished within the level of resources currently available to the FSSA.

(Revised) *Inpatient Substance Abuse Detoxification Services:* FSSA reported that Medicaid currently provides reimbursement for inpatient detoxification services. (The HIP 2.0 waiver also includes inpatient substance abuse treatment as a benefit.) DMHA reported that the degree of medical necessity that is applied by the limited number of providers for these specialized services may be limiting the current pool of patients that have services reimbursed. DMHA reported that currently the medical necessity criteria applied may be that the patient is at risk of death without detoxification. The number of available providers of inpatient detox services may be the limiting factor in the provision of this service to Medicaid recipients. If the state would be required to increase access as a result of including inpatient detoxification as a State Plan service, cost could increase as the demand for services is addressed.

(Revised) *Methadone Provisions:* The bill prohibits Medicaid, Medicaid managed care organizations, state employee health plans, and policies of accident and sickness insurance from paying for methadone claims if prescribed for the treatment of pain. Providers could continue to prescribe the drug for pain, but patients would be required to provide payment. This provision has an unknown impact on Medicaid since savings may be offset by the substitution of a more costly product for methadone. The same impact may be true for the state employee health plans. The extent to which methadone is prescribed for pain in either program is not known at this time. [*This information will be updated when available*.]

Additional Information:

There are currently 13 OTPs operating in the state. DMHA has reported that 8 of the providers take third-party payments; 3 providers are community mental health centers; and that other than the CMHCs, none of the treatment programs are enrolled as Medicaid providers. DMHA reported that the CMHCs do not bill Medicaid for OTP services, instead using federal block grant monies for services that are provided to high-profile opioid drug abusers, such as pregnant women, IV drug abusers, and HIV-positive individuals. Medicaid does not currently reimburse for methadone used for opioid abuse treatment.

DMHA reported that 15,242 total patients were treated in the opioid treatment programs in CY 2013. About 69%, or 10,464 patients, were Indiana residents. Of the Indiana residents, 1,274 were served by state-funded programs through the CMHC.

(Revised) *Opioid Treatment Drugs*: Naltrexone (Vivitrol) is a nonaddictive, long-lasting drug that is injected on a monthly basis to treat individuals with an addiction to opioid or alcohol. The extended release version of the drug that is used for opiate addiction treatment is reimbursed by Medicaid at approximately $1,100 per injection.

Buprenorphine/naloxone is an addictive drug used to treat opioid addiction. DMHA reported in 2012 that the wholesale cost of the drug is $17.00 per 100 mg. Clients in OTPs were reported to pay $70 to$300 per week for this drug. Medicaid reimbursement is reported to average $210 per claim, and 32,433 claims were paid for this drug combination in 2014.

Methadone is an addictive drug that was reported to cost in 2012, $11.49 per 100 mg. Clients in opioid treatment programs were reported to pay in a range of $65 to $101.50 per week. FSSA reported that currently Indiana Medicaid regulations do not allow reimbursement for methadone as a substance abuse maintenance drug. It is reimbursed for substance abuse treatment only when it is used by CMHCs in detoxification treatment or if it is prescribed for pain management. (Under current pharmacy laws, it is prohibited for a pharmacist to fill an addictive prescription for known drug abusers; the pharmacist would be subject to disciplinary actions by the Board of Pharmacy.) Buprenorphine/naloxone is reimbursed for substance abuse treatment by Medicaid only if prescribed by specified physicians.

Explanation of State Revenues: (Revised) If the number of OTPs increase, the DMHA fee assessed to recover administrative expenses associated with regulation of the program could increase. Fees are limited to no more than $75 per person.(Last year, the OTPs were billed $26 per person for DMHA administration costs.)

Explanation of Local Expenditures: Probation programs and problem-solving courts would be permitted to require offenders to receive naltrexone extended release as an opioid abuse treatment medication.

Explanation of Local Revenues:

State Agencies Affected: Department of Corrections, FSSA, DMHA.

Local Agencies Affected: Probation programs and problem-solving courts.

Information Sources: FSSA, DMHA, Minutes of the July 30, 2014 meeting of the Interim Study Committee

on Public Health, Behavioral Health, and Human Services; IC 12-23-18-3 OTP Fee.

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